Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BEHAVIORAL PSYCHOLOGY CLINIC PC
5201 S WESTMORELAND ROAD
DALLAS TX 75237-1622

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
February 9, 2012

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-1982-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the above-referenced patient was approved for a Chronic Pain Management program at The Rehab Group…The insurance company paid for the following dates of service: 3/15/11, 3/21/11, 3/22/11, 3/23/11, 3/25/11, 3/28/1, 03/29/11 and 3/31/11. Therefore, the insurance company should pay the remainder of the certified dates of services in section **V** of the **DWC060.** The initial denial of payment indicates insufficient documentation for dates of service 3/02/11, 3/03/11, 3/04/11, 3/07/11, 3/08/11, 3/09/11, 3/10/11, 3/11/11, 3/14/11. Claims were resubmitted for reconsideration with documentation of the treatment received according to **Rule 133.250**. The insurance company then denied this reconsideration of payment based on extent of injury. All claims submitted thereafter were denied based on extent of injury."

Amount in Dispute: $15,037.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute for consideration.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2011	97799-CP-CA x 6.75 hours	$1,012.50	$750.00
March 3, 2011	97799-CP-CA x 7.5 hours	$1,125.00	$937.50
March 4, 2011	97799-CP-CA x 8 hours	$1,200.00	$1,000.00
March 7, 2011	97799-CP-CA x 7.5 hours	$1,125.00	$937.50
March 8, 2011	97799-CP-CA x 7 hours	$1,050.00	$875.00
March 9, 2011	97799-CP-CA x 7 hours	$1,050.00	$875.00
March 10, 2011	97799-CP-CA x 7.5 hours	$1,125.00	$937.50
March 11, 2011	97799-CP-CA x 7.5 hours	$650.00	$937.50
March 14, 2011	97799-CP-CA x 6.5 hours	$650.00	$812.50
April 7, 2011	97799-CP-CA x 8 hours	$1,200.00	$1,000.00
April 8, 2011	97799-CP-CA x 8 hours	$1,200.00	$1,000.00
April 18, 2011	97799-CP-CA x 8 hours	$1,200.00	$1,000.00
April 19, 2011	97799-CP-CA x 7 hours	$1,050.00	$875.00
April 22, 2011	97799-CP-CA x 4 hours	$600.00	$0.00
TOTAL		$15,037.50	$11,937.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 requires preauthorization for chronic pain management programs provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 7, 2011
   - 1 – (16) – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 1 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. (X358)

   Explanation of benefits dated May 7, 2011
   - 1 – 219 – Based on extent of injury.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated May 23, 2011
   - 1 – 219 – Based on extent of injury.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated June 23, 2011
   - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice). (U301)
   - 2 – Formatted EOR Message unavailable Z362

   Explanation of benefits dated August 19, 2011
   - 1 – 219 – Based on extent of injury.

   Explanation of benefits dated January 17, 2012
   - 1 – 219 – Based on extent of injury.

Issues

1. Has the extent of injury issue been resolved?
2. Is the respondent's denial reason code "16" supported?
3. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.204(h)?
4. Is the requestor the requestor entitled to reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. A Benefit Review Conference was held on March 4, 2010 to mediate resolution of the disputed issue however, the parties were unable to reach an agreement. A Contested Case Hearing was held on April 15, 2010 to decide if the compensable injury of June 9, 2008 extends to include disc pathology, degenerative conditions, or other conditions of any kind at T11-12, L1-2, L2-3, L3-4, L4-5, or L5-S1 in the lumbar or thoracic spine. It was determined by the Division, that the injured employee's compensable injury of June 9, 2008 does include the disc herniation at L4-5 but does not extend to include disc pathology, degenerative conditions, or other conditions of any kind at T11-12, L1-2, L2-3, L3-4, L4-5, or L5-S1 in the lumbar or thoracic spine, other than the disc herniation at L4-5. The provider billed with the following ICD-9 codes on the CMS 1500 forms: 724.2 (Thoracic/Lumbosacral); 847.2 (Lumbar Sprain/Strain; and 722.10 (Displacement Lumbar Intervert). The Division has determined that the extent of injury issue has been resolved, and the disputed services will be review per the applicable Division rules and fee guidelines.

2. The respondent denied reimbursement based upon claim/service lacks information needed for adjudication. 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." A review of the submitted documentation finds that the requestor's documentation supported the services billed, with the exception of dates of service March 2, 2011 and April 22, 2011. For this reason, the Division finds that the 16 claim adjustment code is supported.
3. Per 28 Texas Administrative Code, Section §134.204(h)(5)(B) states, Reimbursement shall be $125.00 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." A CARF accredited program is indicated by using the modifier –CA. The requestor did provide the CARF accredited modifier; therefore, the monetary value of the program will be 100% of the CARF accredited value.
4. The Division finds that total allowable for CPT code 97799-CP-CA will be reimbursed at $125.00 per hour as follows:

   DOS March 2, 2011: Medical records submitted supports 6 hours. Therefore, the recommended reimbursement is $125.00 x 6 hours = $750.00

   DOS March 3, 2011: Medical records submitted supports 7.5 hours. Therefore, the recommended reimbursement is $125.00 x 7.5 hours = $937.50

   DOS March 4, 2011: Medical records submitted supports 8 hours. Therefore, the recommended reimbursement is $125.00 x 8 hours = $1,000.00

   DOS March 7, 2011: Medical records submitted supports 7.5 hours. Therefore, the recommended reimbursement is $125.00 x 7.5 hours = $937.50

   DOS March 8, 2011: Medical records submitted supports 7 hours. Therefore, the recommended reimbursement is $125.00 x 7 hours = $875.00

   DOS March 9, 2011: Medical records submitted supports 7 hours. Therefore, the recommended reimbursement is $125.00 x 7 hours = $875.00

   DOS March 10, 2011: Medical records submitted supports 7.5 hours. Therefore, the recommended reimbursement is $125.00 x 7.5 hours = $937.50

   DOS March 11, 2011: Medical records submitted supports 7.5 hours. Therefore, the recommended reimbursement is $125.00 x 7.5 hours = $937.50

   DOS March 14, 2011: Medical records submitted supports 6.5 hours. Therefore, the recommended reimbursement is $125.00 x 6.5 hours = $812.50

   DOS April 7, 2011: Medical records submitted supports 8 hours. Therefore, the recommended reimbursement is $125.00 x 8 hours = $1,000.00

   DOS April 8, 2011: Medical records submitted supports 8 hours. Therefore, the recommended reimbursement is $125.00 x 8 hours = $1,000.00

   DOS April 18, 2011: Medical records submitted supports 8 hours. Therefore, the recommended reimbursement is $125.00 x 8 hours = $1,000.00

   DOS April 19, 2011: Medical records submitted supports 7 hours. Therefore, the recommended reimbursement is $125.00 x 7 hours = $875.00

   DOS April 22, 2011: Medical records submitted do not support the 4 hours billed. Therefore, reimbursement is not recommended.

   TOTAL DUE: $11,937.50

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 11,937.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,937.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 21, 2012 Date
Signature	Medical Fee Dispute Resolution Officer	June 21, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.